## Illinois Department of Public Aid Chronic Renal Disease Program

## **Summary of Medical Criteria for Patient Selection**

Patient's	s Name:		Age (Years)	): Race:		
Address	: (Number and Street)	(City)	(State)	(Zip Code)	(Cour	nty)
Dialysis	Center:					
1.	General Criteria - Patient evaluation indicates:  a. Presence of end stage renal disease  b. Absence of other disabling irreversible or life-thre c. Probable cooperation and understanding by self ar recommendations for treatment	nd/or family to accept			Yes Yes	No No
2.	Present diagnosis of renal disease:			<b>.</b>		
				Biopsy:	Yes	No
3.	Date of first dialysis (mm/dd/yyyy)					
4.	Is patient a candidate for home dialysis?  If not, which of the following apply?				Yes	No
	a. Severe complicating illness				Yes	No
	Organic or psychological (Specify) b. Unsuitable home environment (Specify)				Yes	No
	c. Severe mental retardation				Yes	No
	d. No home partner				Yes	No
	e. Active substance abuse				Yes	No
	f. Other demonstrable cause (Specify)				Yes	No
5.	Is patient a candidate for renal transplantation? If not, which of the following apply?				Yes	No
	a. Age greater than 55 years				Yes	No
	b. Cancer (excluding basal and squamous cell of skir	n) within past 5 years _			Yes	No
	c. Chronic incurable infection				Yes	No
	d. Severe chronic obstructive pulmonary disease				Yes	No
	e. Other cause (Specify)				Yes	No
6.	Medical care plan: a. Plans for immediate care:					
	b. Plans for future care:					
	Date (mm/dd/yyyy) Renal Dialysis Director -	- Center				

## **Important Notice**

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83-99. Disclosure of this information is mandatory. This form has been approved by the Forms Management Center. IL482-0713